

COMMONWEALTH OF MASSACHUSETTS  
DEPARTMENT OF MENTAL HEALTH

*DMH Access Request Approval Letter*

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Date: \_\_\_\_\_

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Re: Approval of Request to Access Protected Health Information

Dear \_\_\_\_\_:

The Department of Mental Health (DMH) received the attached request from you to inspect and/or copy Protected Health Information (PHI). Your request has been approved. **(ATTACH A COPY OF THE REQUEST FORM.)**

☐ The requested PHI will be available for inspection or pick up, as requested, at the following DMH location:

\_\_\_\_\_.

To set up a time to review or pick up the PHI, please call \_\_\_\_\_ phone \_\_\_\_\_

☐ A copy of the PHI is being mailed to the address indicated on the request form.

☐ There is a fee for copying the requested PHI.

The fee is \$\_\_\_\_\_. Payment can be by cash, check or money order made payable to the Commonwealth of Massachusetts.

- To pick up the PHI, please call me at the number below to arrange a time. Payment must be made at time of pick up.
- For PHI that will be mailed, please send a payment (check only) to:\_\_\_\_\_  
\_\_\_\_\_. The copies will be mailed to the requested address upon receipt of payment.

If you want to modify or withdraw your request, or appeal the fee charge, please call me at the number below.

Sincerely,

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

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